My claim is nondisabling … What does that mean?

For injured workers

Claim classification

When insurers accept an on-the-job injury claim (written request for benefits), they decide whether to process the claim as nondisabling or disabling. They send the worker a letter saying that the claim is accepted and if it is nondisabling or disabling.

What is a nondisabling claim?

For an on-the-job injury claim to be nondisabling, it must meet all of the following:

- It requires only medical services. For example, you don't need to be off work other than to see a health care provider.
- It results in your health care provider letting you return to work within the first three days after you left work to get treatment for the injury. **(*The first three calendar days you are off work are called the "three-day wait" and are not paid unless you remain unable to do any work for 14 days in a row or are in the hospital overnight.)**
- It is not likely to result in permanent loss of use or function of a part of your body or limitations to your ability to work at the job you did when you were hurt.

What is a disabling claim?

It is a claim for an on-the-job injury that either:

- Requires medical services **and** temporary disability benefits ("time loss" is reimbursement for time or wages you lost from your job after your injury).

or

- Is likely to result in permanent loss of use or function of a part of your body or limited ability to work at the job you did when you were hurt.

How does an insurer process a nondisabling claim?

When processing the claim, the insurer:

- Pays medical bills for treatment related to the compensable injury.
- Does not pay time loss because you have not lost time or wages (**see * previous)**.
- Places the claim in "inactive" status when you no longer need care from a health care provider.

What is different about how a disabling claim is processed?

When processing the claim, the insurer:

- May pay time loss if you lose time or wages because you cannot do your usual work **(see * previous)**.
- Closes it with a Notice of Closure when your doctor says you are medically stationary (your condition is not likely to improve with more treatment or the passing of time) and determines the extent of any permanent disability.

How are disabling and nondisabling claims processes the same?

- The insurer issues a notice telling you what conditions are accepted

WORKER PROTECTION

WCD Workers' Compensation Division

Department of Consumer and Business Services

and whether the claim is classified as nondisabling or disabling.

- Your health care provider can treat you for your compensable injury until additional treatment will no longer help you.
- The insurer will reopen (or start actively handling again) the claim only if your health care provider sends in a medical report and form asking for more care.

Changing the claim status

What if I do not like how the insurer classified my claim?

If you think the insurer has not classified your claim correctly, you must send the insurer a letter asking for a review of the decision. Keep a copy of the letter you send, in case you need to take further action. You must ask for this review **within one year** of the date your claim was accepted. Within 14 days of receiving your request, the insurer must send you a letter to let you know the result of the review.

What if the insurer refuses to change the status of my claim?

If the insurer replies that your claim remains nondisabling and you do not agree with the decision, or if the insurer does not answer your letter within 14 days, you can ask the Workers' Compensation Division to review your claim. To request the review, fill out Form 2943, "Worker Request for Claim Classification Review"and send it to the division. If you need help filling out the form, call Appellate Review at 503-947-7816.

Before the Workers' Compensation Division can take action, you must make your request for a review in writing within 60 days of the date on the insurer's letter refusing to reclassify your claim. Send a copy of your letter to the insurer and any response you received to the division, along with your request for review.

What happens after the division gets my request for review?

The division will send a letter to the insurer — you will get a copy — to let the insurer know you have asked for a review. The letter also asks the insurer for a copy of the file on your claim. The insurer has 14 days to send the file to the division.

How long will the division take to review my claim?

The law does not state how long the division has to review your claim. However, the division tries to finish the review and send out an order no later than 60 days after receiving your request.

Service Directory

The insurer

The insurer's name, address, and phone number are on its forms and letters.

Ombuds Office for Oregon Workers

The ombuds will help you understand your rights and explain if other benefits may be available to you.

503-378-3351, 800-927-1271 (toll-free)

oregon.gov/dcbs/oow

Workers' Compensation Division

Appellate Review

Call for information about appealing your claim status.

503-947-7816
800-452-0288 (toll-free)

Benefit Consultation Unit

Call for general information about your claim.

503-947-7585
800-452-0288 (toll-free)

workcomp.questions@dcbs.oregon.gov

Oregon State Bar

You may want to consult with an attorney. For more information, contact the Oregon State Bar at 800-452-7636 (toll-free).

osbar.org

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P.O. Box 14480
Salem, OR 97309-0405

800-452-0288 (toll-free)

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